NATIONAL HEALTH LAW PROGRAM

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Executive Director

September 19, 2014

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Healthy Indiana Plan 2.0 and Health Indiana Plan

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of Indiana's proposed § 1115 demonstration applications: the Healthy Indiana Plan 2.0 (HIP 2.0) and the contingent Healthy Indiana Plan (HIP) renewal.

NHeLP recommends that HHS <u>not</u> approve the HIP 2.0 or HIP applications as requested. The applications include numerous provisions that clearly are not authorized by any law. We urge HHS to address these problems and require Indiana to bring the proposals into a legally approvable form. We urge HHS to work with Indiana to achieve a Medicaid expansion that will serve future Medicaid enrollees well, including Indiana residents affected by this proposal and those in other states who may affected by similar proposals. In its review, we urge HHS to zealously enforce its stated policies and the words of the Social Security Act's § 1115.

In addition, we ask that before taking action on this request, HHS address its own "stewardship of federal Medicaid resources." GAO, *Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency* at 32 (June 2013). As the GAO has concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented….[T]he policy and processes lack transparency regarding criteria." *Id. see also*, *e.g.*, GAO Letter to The Honorable Orrin Hatch and The Honorable Fred Upton re: Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver

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Raises Cost Concerns at 3 (Aug. 8, 2014) (listing ways in which HHS did not ensure budget neutrality). Given the repeated findings that HHS is not engaging in sound management practices, we urge the agency to fix the problems before approving any additional § 1115 programs.

HIP Now Covers State Plan Populations

We note that prior HHS approvals of Healthy Indiana Plans were based on specific circumstances. Those approvals were implemented prior to the January 2014 effective date of the Affordable Care Act's (ACA) Medicaid expansion. Prior to the ACA, some of the HIP and HIP 2.0 eligible populations below 138% FPL were not described in the Medicaid Act (for example, childless non-disabled, non-pregnant, non-elderly adults). As a result, HHS used its purported "expenditure authority" under § 1115 of the Social Security Act to allow Indiana to provide coverage to this population. However, starting in 2014, individuals below 138% of FPL are a Medicaid state plan population and, thus, can no longer be considered non-Medicaid populations. As a result, HHS can no longer use the expenditure authority to ignore Medicaid requirements. Rather, the State must either fully comply with all Medicaid requirements or obtain a waiver that meets all of the requirements of § 1115 for experimental/demonstration projects, and in the case of cost-sharing, § 1916(f).

We note that Indiana's proposed inclusion of § 1931 parents and caretaker relatives in the HIP 2.0 program only underscores the legal prohibition on treating the HIP 2.0 population as a non-Medicaid population.

A. Limits of § 1115 Waiver Authority

Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[1] Anything outside of § 1902 is not legally waivable through the §1115 demonstration process. Indiana repeatedly requests waiver of requirements that lie outside of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1903, § 1916, § 1916A, and § 1937. None of these waiver requests are permissible because the substantive requirements rest outside of § 1902 and independently require state compliance. In other words, any reference to the provision in § 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions.

B. Premiums and Cost-Sharing Generally

Indiana's § 1115 application contains numerous premium and cost-sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposals repeatedly violate four core requirements for § 1115 demonstrations:

[1] Social Security Act (SSA) § 1115(a)(1).

- As mentioned above, § 1916 and § 1916A are free-standing requirements lying outside of § 1902, which cannot be waived through § 1115. Even if this were not true, *any* waiver of cost-sharing in § 1916 must comply with the waiver requirements of § 1916(f), the *only* legal channel for such waivers. Indiana attempts to waive cost-sharing requirements in § 1916 through § 1115 without following the § 1916(f) requirements. Moreover, section § 1916(f) only applies to cost-sharing. Even if Indiana complies with § 1916(f), the Medicaid prohibitions on premiums for individuals below 150% FPL are still *never* waivable.
- A § 1115 demonstration is precisely that, a demonstration. Indiana's requests for § 1115 authority regarding premiums and cost-sharing are not approvable because, as proposed, and given the well-known results of redundant studies on cost-sharing and premiums, they will not test anything. For example, one of the principal features Indiana seeks to waive, premiums for low-income enrollees, has already been tested repeatedly and consistently shown to *depress* enrollment – including for the very population of adults that is the focus of the Indiana proposals. *See* David Machledt and Jane Perkins, *Medicaid Cost-Sharing and Premiums* (March 2014), available at: http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.UzneLoX3IX5.
- Section 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid Act. The objective of Medicaid is to *furnish* health care to low-income individuals. Many of the enhanced premium and cost-sharing elements in Indiana's proposal cannot be approved because they *reduce* access to care. The Medicaid Act, particularly § 1916A, already provides States like Indiana with a great deal of flexibility to impose premiums, cost sharing, and similar charges. Yet, Indiana seek to run past these options to implement proposals that the research has already established are harmful to low-income people – policies that will clearly result in interrupted care, lost opportunities, and churning.
- Moreover, the State has been serving parts of this population through a § 1115 waiver for almost seven years. Its demonstration has *already established* that even a premium below $5 a month causes lower income individuals to disenroll from health coverage.[2] How can the State be allowed to "test" a premium as part of HIP 2.0 or HIP when its own test has already answered the question? Furthermore, before it receives new § 1115 approval, HHS must require the State to explain the full breadth of what it tested with respect to the population with the previous demonstration project, the results of those tests, how the lessons learned from that project have affected the new proposal, and what new experiments will be conducted regarding this population with the new project. Those lessons must be based on accurate and relevant data; *see*

[2] Healthy Indian Plan 2.0 1115 Waiver Application, 28, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf.

Appendix 1 for concerns with Indiana's data analysis. Our experience with the Arizona copayment demonstration showed us that HHS will grant renewed waivers without requiring the state to establish what it did with the previous waiver. This ignores the entire purpose of § 1115 – to test experimental, pilot or demonstration ideas.

C. Required and Optional Premiums ("Contributions")

Both HIP 2.0 and HIP are premised on monthly contribution systems. Indiana requests these monthly contributions to implement health savings account (HSA) models, though Indiana's proposals appear mistaken about the incentives created and may misrepresent data. *See* **Appendix 1** below for a discussion of the shortcomings of Indiana's HSA approach and high-deductible plans more generally. Indiana's extreme concern with consumer "skin in the game" ignores the fact that Medicaid's legal cost-sharing system already provides generous flexibility for states to create strong incentives for enrollees to avoid unnecessary care. More important, after decades of research into the subject, the Medicaid Act specifically prohibits some of the essential HSA features that Indiana requests. Moreover, the State cannot suggest HSAs as a novel, experimental Medicaid concept because the Medicaid Act already included provisions for the Secretary of HHS to establish demonstration projects under which states could use HSAs, called "health opportunity accounts" in the statute. *See* § 1938. Therefore, as designed, the proposal is not approvable by HHS.

Under the law, HHS should not approve monthly contributions for any individuals below 150% FPL.[3] According to the Medicaid Act, "any enrollment fee or similar charges" are illegal for this very-low-income population, whether they are called monthly fees, assessments, contributions, or premiums.[4] Indiana's "monthly contributions" meet the federal definition of a premium or similar charge. Since monthly contributions are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved. Even if, contrary to the law, HHS considered a waiver of the premium prohibition, it should still not be approvable because, given the well-established studies on the impact of premiums on low-income people, there is no experimental value to premiums nor do they promote the objectives of the Medicaid program, as required by §1115(a).[5] The impact of any premiums on low-income people is clearly visible from Indiana's own data, showing that even a premium below $5 a month causes lower income individuals to disenroll from health coverage.[6] Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost-

[3] *See* SSA §§ 1916(c), 1916A(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not broadly applicable to the Medicaid expansion population. *See, e.g.*, § 1916(d).
[4] SSA § 1916A(a)(3)(A).
[5] For example, in 2003, Oregon experimented with charging sliding scale premiums ($6-$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).
[6] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 28.

sharing protections set at 100% FPL. We note that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

Indiana's proposal is also problematic because of the consequences for failure to pay the premiums. There is no authority in the Medicaid Act for HHS to approve "lockouts" after termination. These provisions will unnecessarily increase the number of uninsured, and thus contradict any effort to promote continuity of care and will harm the provider infrastructure in Indiana (as providers will continue to treat uninsured patients). In fact, Medicaid law requires the opposite of delaying eligibility; Medicaid requires eligibility to be established with reasonable promptness.[7] There is no plausible argument that delaying enrollment into Medicaid for numerous months helps furnish medical assistance. We note further that there is also no authority in Medicaid to require, as Indiana has proposed, that applicants "pay any debt that accrued due to non-payment" of premiums associated with prior terminations and lock-outs.[8] Suffice it to say that HHS cannot approve illegal application recoupments, for illegal premiums, that have been charged prior to illegal terminations and corresponding illegal lock-outs.

We also urge HHS to ensure that in any HIP 2.0 or HIP program Indiana will be prohibited from using lockouts against individuals who fail to submit redetermination materials. Redetermination lockouts have been a part of the current "demonstration" project, and they have established themselves as one of the most problematic features of the current HIP program. State advocates hear regularly from uninsured consumers who are locked out of coverage, sometimes in cases where the individual submitted redetermination materials that she reasonably believed were complete. HHS can only allow continuation of this policy with a showing of evidence about the impact of the current lockout policy, including the data collected, the methodologies used to evaluate that data, the State lessons learned from this experiment, and how the State will ensure that its demonstration will meet Medicaid objective of furnishing medical assistance.

D. Copayments for Non-Emergent ER Use

Indiana has requested §1115 demonstration authority to charge heightened copays of $25 per visit for non-emergent use of the ER. Such copays are only permissible for individuals above 150% of FPL; individuals below 150% can only be charged nominal copayments.[9] Recent regulations provide states with generous flexibility to charge as much as $8 for non-emergent ER visits for populations below 150% FPL.[10] Therefore, CMS cannot approve the request to impose a $25 copay – over three times the legal limit. The law is clear; the policy, heavily studied; there is no role for an experiment, and if there were, it would need to occur pursuant to § 1916(f).

[7] SSA § 1902(a)(3).
[8] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 29.
[9] SSA §§ 1916(a)(3), 1916(b)(3).
[10] 42 C.F.R. § 447.54.

Section 1115 cannot be used to approve such a waiver for a number of reasons. First, as mentioned earlier, the cost-sharing limits in § 1916 cannot be waived under § 1115. Rather, to waive the ER copayments set forth in federal law, the State must meet the tightly circumscribed requirements of § 1916(f).

Additionally, a higher copay would serve no valid demonstration purpose nor promote the objectives of the Medicaid Act. Cost-sharing has already been shown to be a barrier to low-income populations accessing care.[11] Indiana's data purporting to show that ED use declined based on these copays is fraught with error, and perhaps misrepresentation of data. *See* **Appendix 1** for a discussion of the questionable validity of Indiana's ED use data. CMS itself, in a recently released bulletin on best practices to reduce unnecessary ED use, acknowledges that strategies like expanding access to primary care or providing health homes for frequent ED users may be effective, but suggests that increased copays for nonemergency use are problematic.[12] A heightened copay, therefore, offers no positive experimental value and would undermine the objective of the Medicaid Act to furnish medical assistance for enrollees. For additional information, *see* David Machledt and Jane Perkins, *Medicaid Cost-Sharing and Premiums* (March 2014), available at: http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.UzneLoX3IX5. .

We note that the individuals subject to this charge may be extremely poor, and an $8 charge would already give them "skin in the game." Finally, if HHS approved any heightened copayments then HHS would need to carefully monitor Indiana's compliance with statutory requirements that, prior to charging any copay for non-emergent use of the ER, there must be an "actually available and accessible" alternate care option and that the facility must provide notice that the care to be provided is non-emergent care subject to additional charges, identify the alternative care option, and provide the enrollee with a referral.[13]

E. Annual Application of 5% Aggregate Cost-Sharing Cap

Indiana apparently seeks to allow annual calculation of the 5% aggregate cap on Medicaid premiums and cost sharing. Although the HIP 2.0 application states that

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[11] General evidence suggests that increased copays may discourage unnecessary *and* necessary ED care, especially for low-income enrollees. *See* J. Frank Wharam et al., *Emergency Department Use and Subsequent Hospitalizations among Members of a High-Deductible Health Plan*, 297 JAMA 1093, 1098 (2007) and Joe V. Selby et al., *Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization*, 334 New Eng. J. Med. 638 (1996). Evidence specific to Medicaid and CHIP finds that there is no discernible effect on ED utilization (emergency or nonemergency) for Medicaid enrollees. *See* Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 Health Aff. 1643 (2010) and David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 Med. Care Res. Rev. 514–529 (2013).

[12] CMS, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf; see *also* Wash. State Health Care Authority, *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013).

[13] SSA § 1916A(e)(1).

enrollees will not pay more than 5% of their income "[c]onsistent with CMS rules,"[14] elsewhere the application states that "co-payments will be monitored to ensure the individual does not exceed the 5% of *annual* income cap on cost-sharing."[15] While Medicaid law does provide states the flexibility to tabulate the aggregate cap on a *monthly* or *quarterly* basis, it does not allow the aggregate limit to be applied annually.[16]

As described above, the requirements of § 1916 and § 1916A cannot be ignored or waived for the populations subject to the demonstration (as they are state plan populations described in the Medicaid Act). HHS can only approve this change to the aggregate cap if the proposal complies with the additional requirements at § 1916(f). We note that annual caps also should not be approved by HHS because the HIP 2.0 application list does not specifically request waiver authority to apply caps on an annual basis, and HHS should only consider waiver requests that are explicitly stated and subject to comment.

Finally, Indiana does not need annual caps to accomplish the objectives of this demonstration; quarterly caps would not be a barrier towards the State's goals. Furthermore, considering that low-income individuals have little disposable income and the adverse impacts of cost sharing on this population are well known, applying the aggregate cap on a yearly basis would not be consistent with the objectives of Medicaid or serve any demonstration purpose.[17]

F. "Basic" and "Plus" Packages Based on Cost-Sharing

HIP 2.0 proposes that individuals below 100% FPL who make monthly contributions will receive a superior "Plus" package, while those who do not will receive the lower "Basic" package with normal copayments. HHS should not approve such a demonstration involving copayments unless the proposal complies with the requirements of § 1916(f). Furthermore, providing different benefits based on cost-sharing methodology has no experimental value and does not promote the objectives of the Medicaid Act, as required by § 1115.[18]

While Medicaid regulations allow states flexibility to create different alternative benefits plans for different groups, those groups must be "identified by characteristics of individuals."[19] The intent of this flexibility is to allow states to design benefits packages

[14] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 10.
[15] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 30.
[16] SSA §§ 1916A(b)(1)(B)(ii), (b)(2)(A).
[17] To be clear, we would like to provide an example as to why an annual cap would be so detrimental. An individual at 60% FPL would earn $6,894 per year. Her 5% aggregate cost-sharing cap would be $29 per month or $86 per quarter. If she used minimal health care during the year, but had one health crisis month with high-utilization (ex. multiple ED trips), she is protected by a limit of $29 for that month or $86 for that quarter, and that might be her total cost-sharing responsibility for the full year. If an annual limit was used, however, she could pay as much as $345. This would be the equivalent of what she would pay if they if she had the same crisis *every* quarter. Put another way, under the law, her cost for *one event* is limited to 5% of the cost of a quarter, but under an annual cap, her cost is 5% of her annual income.
[18] SSA § 1115(a)(1).
[19] 42 C.F.R. § 440.305(a).

more responsive to the *medical* needs of certain groups of individuals. HHS' preamble to the regulation states that states may not use the flexibility to target based on poverty level, "but rather the benefit package should be designed based on the medical needs of the population being served."[20] Indiana's basis for targeting benefits is not remotely connected to the medical needs of the population and should not be approvable under the regulations.

G. EPSDT

The requests in HIP 2.0 and HIP to eliminate EPSDT services for a subset of 19- and 20-year olds are illegal because, in addition to being required in multiple places in § 1902, EPSDT is specifically required in § 1937 for ABPs (a provision which is not waivable under § 1115, since is lies outside of § 1902, and which Indiana has not sought to waive) and because EPSDT coverage is a primary objective of the Medicaid Act.[21] (We note also that Indiana would not be eligible to receive enhanced matching funds for an ABP that did not include EPSDT, since § 1903(i)(26) only authorizes Medicaid expansion matching funds for providing § 1937 benefits including EPSDT.)

No feature of a § 1115 application can be approved if it is inconsistent with the objectives of the Medicaid Act.[22] Congress designed Medicaid with clear requirements to cover EPSDT for children and youth under age 21. These statutory provisions have been repeatedly amended and strengthened over the years, as research repeatedly documents that poverty-level children and youth need a range of enabling and developmental interventions. Young people are one of the core populations of the Medicaid program and to diminish EPSDT – the most essential and enduring feature of coverage for children and youth – is clearly inconsistent with the objectives of the Medicaid program.[23]

H. Work Search Requirements

HHS should not approve any waiver permitting Indiana to condition Medicaid eligibility on compliance with work search activities. Work search requirements are an illegal condition of eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.[24] Medicaid is a medical assistance program, period. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law,[25] and courts have held additional eligibility requirements to be illegal.[26] Section 1115

[20] 78 Fed. Reg. 42191.
[21] SSA § 1937(a)(1)(A)(ii).
[22] SSA, § 1115(a).
[23] SSA § 1115(a).
[24] *See generally* SSA § 1902.
[25] *Id.* §§ 1902(a)(10)(A), (B).
[26] *Camacho v. Texas Workforce Comm'n,* 408 F.3d 229, 235 (5th Cir. 2005), *aff'g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not "add additional requirements for Medicaid eligibility"). *See generally Carleson v. Remillard,* 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to

cannot be used to short circuit the Medicaid protections, because work search requirements can in no way promote the objectives of the Medicaid Act or demonstrate anything. From a practical stand point, work requirements applied to health coverage get it exactly backwards. An individual needs to be healthy to be able to work, and a work requirement can prevent an individual from getting the health care they need to be able to work. We note finally that in almost any system in which eligibility is conditioned or attached to work search, there are likely to be serious violations of nondiscrimination laws, as persons with disabilities may end up with fewer benefits or higher costs due to their condition or the lack of adequate systemic supports to foster their employment.

We urge HHS to make clear to the state that any state work search programs cannot be tied to Medicaid or otherwise appear tied to Medicaid. We are concerned that states will abuse the confusion of beneficiaries who may think the Medicaid and work search programs are somehow linked. Aside from this, however, we wholeheartedly support efforts by Indiana and other states to create independent and voluntary employment supports for lower income individuals, as accessible employment supports are services that our clients, particularly those with disabilities, have sought and been denied for decades.

I. Non-Emergent Medical Transportation (NEMT)

Medicaid requires coverage of NEMT.[27] This is a core Medicaid requirement, applicable to all state plan enrollees. HHS cannot approve the waivers of NEMT requested in HIP 2.0 and HIP under § 1115 authority. As mentioned earlier, as of January 1, 2014, individuals below 138% FPL are a state plan population. Thus, for HIP 2.0 or HIP renewal, Indiana would need a waiver, and such waivers can only be approved if they have a valid experimental purpose and promote the objectives of the Medicaid Act. There is no valid experimental purpose to <u>not</u> providing transportation – it is clear that beneficiaries will lose access to care. Furthermore, reducing access to care for poor beneficiaries, including ones in isolated rural communities that lack any public transportation, clearly contradicts the objectives of the Medicaid Act. To the extent HHS has (in our view, illegally) approved such a waiver recently in Pennsylvania and Iowa, we believe that HHS should wait until the analysis of those "demonstrations" is completed before authorizing any more experiments that are dangerous and likely to hurt beneficiaries. We believe the evidence will show that NEMT demonstrations do not help furnish care to Medicaid recipients.

J. Retroactive and Point-in-time Eligibility

Medicaid requires states to provide retroactive and point-in-time coverage for enrollees, and provide them with access to Medicaid with "reasonable promptness."[28] Indiana has

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children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

[27] *See* 42 C.F.R. § 431.53; CTRS. MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2113.

[28] SSA §§ 1902(a)(3) and (a)(34); 42 C.F.R. § 435.914 (redesignated at §435.915 in 77 Fed. Reg. 17143).

requested § 1115 demonstration authority to waive these requirements. These waivers should not be allowed because there is no demonstrative value to the request. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers realize they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms. For these same reasons, the § 1115 demonstration should not be approved because this does not promote the objectives of the Medicaid Act.

K. Medicaid FPSS and EHB Preventive Services Requirements

HHS should clarify in any HIP 2.0 or HIP approval that the proposed benefits packages will comply with the legal minimums for family planning services and supplies. The coverage packages proposed under both demonstrations are Medicaid "alternative benefits plans" (ABP) which have two clear and independent requirements under § 1937. First, all ABP coverage must comply with the essential health benefits requirements, which have their own standards for preventive services, including coverage of all FDA-approved contraceptive methods.[29] Second, all ABPs must include family planning services and supplies as per the Medicaid requirements at § 1905(a)(4)(C) .[30] There may be circumstances under which one of these family planning standards is more robust and less restrictive than the other. Ultimately, the HIP 2.0 and HIP demonstrations can only be legally approved if they comply with *both* requirements. In the case of HIP 2.0, the description of benefits appears to ignore the § 1905(a)(4)(C) requirement, stating that it is "[l]imited to ACA required preventive services."[31] (In the case of the HIP renewal, the description of benefits ignores the essential health benefits requirement, stating that "the State seeks approval for the current HIP benefit package … to continue to be designated Secretary-approved coverage.")[32] Both proposals must be amended to indicate compliance with *both* the § 1905(a)(4)(C) and essential health benefit requirements.

Additionally, although the HIP renewal application clarifies that abortion is not covered as a "family planning service," HHS should remind the State of its legal obligation to cover abortion services in the circumstances required by law.

L. Freedom of Choice for Family Planning Services and Supplies

Both the HIP 2.0 and HIP renewal applications include broadly worded requests for waiver of freedom of choice. While freedom of choice may be waived for many services, freedom of choice for family planning services and supplies cannot be waived under the law. HHS and a number of district and federal circuit courts of appeal have consistently

[29] § 1937(b)(5).
[30] § 1937(b)(7).
[31] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 25.
[32] Healthy Indian Plan 1115 Waiver Application (renewal), 8, available at: http://www.in.gov/fssa/hip/files/HIP_Waiver_Renewal_%28Final_6_30_14%29.pdf.

made clear that states must cover family planning services and supplies provided by any qualified provider, including out-of-network providers.[33] Therefore, HHS should clarify that, regardless of any approval of freedom of choice waiver requests in HIP 2.0 and HIP, individuals remain entitled to obtain out-of-network coverage for family planning services and supplies, regardless of whether there are available in-network family planning providers.

M. Coverage for Pregnant Women

We support the provisions in the HIP 2.0 proposal that would allow pregnant women to elect to maintain their ABP coverage and receive all additional benefits and cost-sharing protections to which pregnant women are entitled under the state plan. However, in any proposal HHS should clarify that a pregnant woman remains eligible for these enhanced benefits and cost-sharing protections not only for the duration of pregnancy, but through the month in which the 60-day post-partum period ends, even if she has a change in income otherwise making her ineligible.[34]

Further, women eligible for pregnancy-related Medicaid coverage may also be eligible for advance premium tax credits to purchase coverage through the Marketplace. HHS should ensure that all pregnant women in Indiana's system – whether covered under Hoosier Healthwise or HIP 2.0 – have timely and appropriate information about all of their coverage options so they may elect the coverage option(s) that best meet their needs.

N. Transparency

We urge HHS to carefully review whether Indiana has faithfully engaged in the required § 1115 transparency process for the state level comment process. After a meticulous read of the final application, we only detected three substantive changes to the HIP 2.0 proposal after state comments (adding work search requirements for part-time students, higher premiums for individuals 75-100% FPL, and addition of hearing aids as a covered service), of which *none* is mentioned in the "Public Comment" summary. Two of these changes create new barriers for consumers. None of the harms to consumers identified in comments received by the state were addressed (except possibly the lack of hearing aids, though it wasn't mentioned in the comment summary). In short, it appears the HIP 2.0 and HIP programs were not altered in any way based on any consumer stakeholder comment received in the comment period. Although the state received hundreds of comments, Indiana claims "[the State… received six (6) comments regarding the required copayments for the non-emergency use of hospital emergency department (ED)" and "[a]ll comments were in favor of the ED copayment structure, citing positive results in utilization under the current HIP program."[35] NHeLP filed comments with Indiana that explicitly state the ED copayments were unlawful, unnecessary, and bad policy. If HHS allows Indiana's approach to the comment period

[33] *See* CMS, State Medicaid Manual, § 2088.5.
[34] SSA §1902(e)(6).
[35] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 48.

to pass muster, it will send a message to states that comment periods are merely waiting periods, and nothing more.

Conclusion

In summary, we have numerous concerns with the legality of Indiana's § 1115 demonstration application, as proposed. Please know that we fully support the use of § 1115 of the Social Security Act to implement true experiments. We strongly object, however, to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. We urge HHS to address our concerns prior to issuing any approval. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org) or Jane Perkins (perkins@healthlaworg). Thank you for consideration of our comments.

Sincerely,

Elizabeth G. Taylor,
Executive Director

Appendix 1

HIP and HIP 2.0 Models and Literature on Cost Savings in High Deductible Health Plans (HDHPs)

NHeLP does not support the type of care model that Indiana proposes to disincentive consumers to get care, because we do not believe these models are effective. The reality is that consumers almost always rely entirely on their providers' judgments about what care they should obtain. To the extent that the overwhelming majority of Medicaid recipients are in some kind of managed care program, that program has been charged with selecting only qualified providers and it is the responsibility of the managed care program to ensure their providers are effectively prescribing--not the responsibility of consumer to judge the effectiveness of the prescribing (and note, when consumers don't follow through with prescribed treatments they are blamed and labled as "non-compliant"). Managed care programs should be ensuring efficient care through sound clinical policies and use of high quality providers, not creating hurdles for consumers to access prescribed care. As a past director of the Arizona Medicaid program has noted, cost sharing (of the type proposed by Indiana) does not work in managed care; rather, it gets in the way of the managed care's ability to manage. Nonetheless, states continue to emphasize financially incentive-based hurdles instead of focusing on things like care coordination. Indiana's proposal describes HIP and HIP 2.0 as Health Savings Account (HSA) coverage models that will incentivize efficient care, but Indiana's own on-point evidence does not support this (and additionally raises the question of how the proposal could be part of a new 1115 experiment).

The proposed HIP 2.0 more closely resembles a coverage plan with a premium but no cost sharing (apart from nonemergency ED use). That means that even *if* we assume that incentive based policies for consumers make any sense, individuals have little financial incentive to reduce their service use in Indiana's model of care. The current HIP program provides enrollees with a $1,100 "POWER" account, and attempts to incentivize enrollees to reduce services by also setting a $1,100 <u>deductible</u> on coverage. Individuals can use their account to meet the deductible, and are incentivized to use care "responsibly" because they can roll over a portion of any amount left over in their account after the first year. However, the incentive is more fiction than fact in HIP or HIP 2.0. According to Indiana's most recent demonstration proposal, only *a third* of current HIP enrollees end up with money left in their account at the end of the year.[36] For two-thirds of the population, the incentive scheme is simply irrelevant. Most of the one-third of individuals with leftover funds may only stand to benefit minimally in the subsequent year, since many of these individuals will only have a miniscule value left in their account (i.e., if two-thirds of the individuals exhausted their account entirely, there will be many who finish with only a few dollars left in their account). Moreover, the rollover is only even *possible* if the individual also completes required wellness requirements, is current on their payments, and successfully completes the full

[36] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 34.

reenrollment application within a required time limit. Even if the state raises its annual deductible to $2,500, as proposed in the HIP 2.0 application, a large proportion of enrollees will end up with no rollover, often through no fault of their own -- they just happened to get sick or have some condition. Ultimately, since the rollover will help so few people, the policy creates very little incentive for consumers to use care efficiently and "save up" in their account. It will certainly be less influential to low income consumers than a cost-sharing model as intended and legally required under the Medicaid Act.

Moreover, the rollover incentive, even if it were more robust, would do little to incentivize good care and cost-efficiency, and might in fact do harm. When faced with deductibles or standard across-the-board cost sharing, studies have repeatedly shown that individuals reduce both essential and nonessential care in roughly equal proportions.[37] Studies specifically of true high-deductible health plans (HDHPs) indicate that much of the initial reduction in services concentrates in discontinuation of prescriptions, including for chronic conditions like hypertension.[38] It comes as no surprise that an individual looking to cut costs may first stop a medication for a largely asymptomatic condition. However, the literature clearly shows that lower adherence to such medications correlates strongly with adverse health outcomes and offsetting costs due to more frequent hospitalizations.[39] These data suggest that over time, initial HDHP savings associated with reduced prescription drug use will likely lead to poorer health outcomes and possibly higher inpatient care and emergency department costs over the long term.[40]

Indiana's HIP 2.0 does include preventive services with no cost sharing – a structure meant to incentivize proven cost-effective preventive care. However, that requirement applies to Medicaid expansion in every state and thus HIP 2.0 will test nothing new or innovative in this regard. Rather, the HIP 2.0 model may actually be *worse* than the standard Medicaid approach: evidence from HDHP research shows that a many enrollees do not understand that preventive services do not apply to their deductible.[41] In one case, nearly a third of low-income HDHP enrollees report delaying or forgoing preventive care due to the deductible even when that care was actually available at little

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[37] Judith H. Hibbard et al., *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 MED. CARE RES. REV. 437 (2008); Robert H. Brook et al., RAND Corp., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (2006), http://www.rand.org/pubs/research_briefs/RB9174.html;

[38] Jessica Greene et al., *The Impact of Consumer-Directed Health Plans on Prescription Drug Use*, 27 Health Affairs 1111 (2008).

[39] Bruce Stuart et al., *Does Medication Adherence Lower Medicare Spending among Beneficiaries with Diabetes?*, 46 HEALTH SERVICES RES. 1180 (2011); Michael T. Eaddy et al., *How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review*, 37 PHARMACY & THERAPEUTICS 45 (2012).

[40] Paul Fronstin & M. Christopher Roebuck, Employee Benefit Research Institute, *Health Care Spending after Adopting a Full-Replacement, High-Deductible Health Plan With a Health Savings Account: A Five-Year Study* (2013), http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-13.No388.HSAs.pdf.

[41] Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care*, 31 HEALTH AFF. 2641 (2012); Mary E. Reed et al., *High-Deductible Health Insurance Plans: Efforts To Sharpen A Blunt Instrument*, 28 HEALTH AFF 1145 (2009).

or no cost to the enrollee.[42] Indiana's HIP proposal thus adds significant complexity to the incentive structure (rollovers, deductible exempt services, multiple contributors, etc.) without a clear benefit in terms of incentivizing more cost-effective services, improving care coordination, or making health care delivery more efficient.

In an attempt to justify the HSA approach, Indiana's proposal also misrepresents statistical evidence and overstates the potential savings from an HSA design. For example, the proposal (at page 7) cites a study that found a 25% reduction in overall care costs in the first year after an employer implemented an HSA plan.[43] However, the proposal fails to mention that the cited study actually covered four years of data, and that by the fourth year, there was no significant difference between the overall expenditures for the HDHP plan vs. the control.[44] Nor does the proposal mention that in that first year, the HDHP didn't actually reduce expenditures; it reduced costs relative to the control. The matched control plan's costs rose 29% in that first year – the authors acknowledge they have no explanation why – which indicates the large relative drop is likely an anomaly more attributable to the control than to the HDHP plan.[45]

A more honest review of the literature reveals mixed results for HDHPs, and *at best* slight short-term savings.[46] Most studies to date only evaluate the first year after implementation and do not account for differences in health outcomes.[47] Other multiyear studies, similar the Fronstin & Roebuck study cited above, have found that total savings for HDHPs erode in subsequent years.[48] Indiana's proposal cites a multi-year Mercer study of the Indiana's state employee HDHP and claims that it has averaged savings of 10.7% over four years.[49] However, according to Mercer's methodology, the savings derive from differences in costs only in the first year after enrollees transition to an HDHP.[50] These transitions have occurred in each of the four study years. Mercer does not appear to evaluate what happens to expenses in the second year after an individual has transitioned to an HDHP, though it does include a graph indicating that the second year expenses seem to rise substantially for a number of the cohorts (see red, blue, and green lines below).[51]

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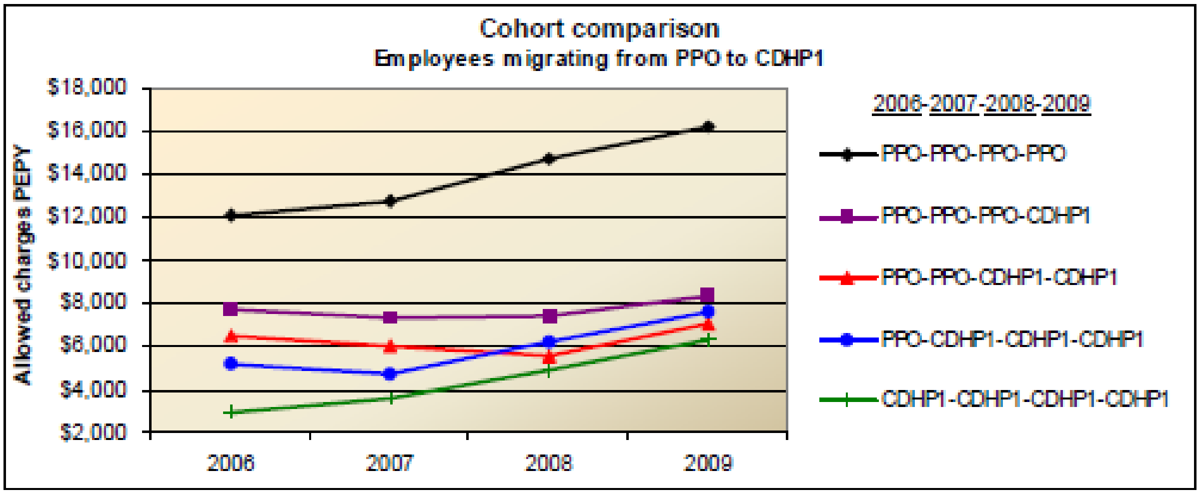
[42] *Id.*
[43] The cited study is: Paul Fronstin & M. Christopher Roebuck, *supra* note 5.
[44] *Id.* at 7.
[45] *Id.* at 7, 12.
[46] M. Kate Bundorf, Robert Woods Johnson Found., *Consumer-Directed Health Plans: Do They Deliver?*, (2012), http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405.
[47] *Id.*
[48] Judith H. Hibbard et al., *Does Enrollment in a CDHP Stimulate Cost-Effective Utilization?*, 65 MED. CARE RES. REV. 437 (2008). *See also* Bundorf, *supra* note 9.
[49] *See supra* note 2, Healthy Indian Plan 2.0 1115 Waiver Application, at 7.
[50] The figure used to derive the savings is based on the consumerism/behavior change variable. *See* Cory Gusland et al., Mercer Health & Benefits, LLC, *Consumer-Driven Health Plan Effectiveness, Case Study: Indiana*, 14 (2010), www.in.gov/spd/files/CDHP_case_study.pdf.
[51] *Id.* at 6.



HIP and HIP 2.0 Models and Emergency Department Copays

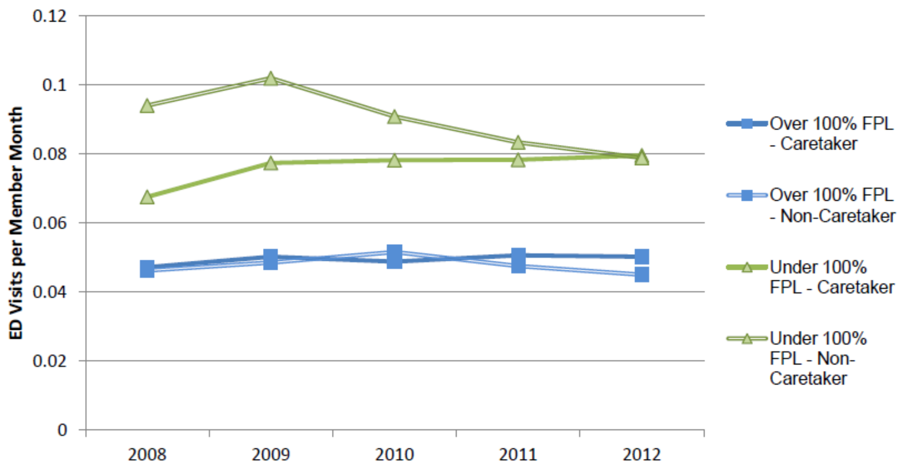
Indiana's HIP 2.0 proposal includes a provision that would allow the state to institute a graduated copay for nonemergency use of the ED. Specifically, the state would charge $25 for a second nonemergency use of the ED. NHeLP's comment above discusses the illegality of this proposal.

In proposing this $25 copay, the state cites the success of HIP's current $25 copay in place for noncaretaker adults. However, the proposal's presentation of data around the success of its current $25 copay is misleading.

First, the proposal includes a graph (at page 34) showing a large drop in ED utilization among non-caretaker adults while showing ED rates for caretakers to be relatively constant across four years. This graph is pulled from the 2012 HIP program annual report, but leaves out the year 2008, which showed a large *increase* in ED rates among non-caretaker adults (see figure 6.6 below).

Second, the text explaining Indiana's current policy of charging $3 for caretaker adults does not reflect the actual policy prior to 2014. In the years shown in the graph (2009-2013), caretaker adults with incomes above 100% FPL faced nonemergency ED copays ranging from $6 to $25. The graph below shows that among this group, *ED rates failed to decline at all* despite facing higher copays for nonemergency visits.

Figure 6.6 Rate of Emergency Room Visits Per Member Per Month, 2008 through 2012 (self-reported)



Source: Mathematica analysis of 2013 survey of HIP members.

If the ED copay is indeed responsible for the observed decline in ED rates among non-caretaker adults, one would expect that the rates for caretaker adults over 100% would decline somewhat, as a significant portion of this population faced *exactly the same* copayments as non-caretakers during the relevant period of measurement.

In fact, the only difference in application of copays was in how the state determined a "nonemergent" situation for these two populations, and this would favor using the caretaker results (which showed no decline in ED use) instead of the non-caretaker results that Indiana conveniently relies on in its application. The caretaker data is more apt because the caretaker adults underwent a nonemergency screening before being charged a copay, which is the same process that Indiana proposes it will apply in the HIP 2.0 demonstration. For non-caretaker adults, in contrast, the copay applies to any visit that does not result in a hospital admission. This is a different standard than is proposed in the HIP 2.0 demonstration. In summary, the data showing decreased ED use is mixed, and the data showing no decrease is actually a better evidence for what Indiana is doing in HIP 2.0. (This also makes clear that the HIP non-caretaker adults group makes a poor "control group" for the current demonstration evaluation). We note also that in any case, Indiana's definitions are not consistent with the prudent layperson standard mandated by Medicaid cost sharing law.

Indiana has cherry-picked data (ignoring the 2008 data and using non-caretaker adults as the "evidence" group) to prove a conclusion that the data does not support. The evidence Indiana presents that higher copays for non-emergent ED use are an effective utilization is ultimately biased.

One final important point to raise with regard to ED copays is that the same report the state draws on to show "declining" rates for non-caretaker adults includes a very important caveat to the ED utilization data. Based on surveys of HIP enrollees who had visited the ED, *more than two thirds* reported never being asked to pay an ED copay.

This includes non-caretaker adults who should have automatically been assessed a copay if they did not get admitted (typically only 10-15% of ED visits result in admission). The implication of this survey is that many hospitals viewed the copay as an unnecessary additional administrative burden and did not bother to collect it. The evidence that the copay was so rarely applied increases the likelihood that any observed decline in ED utilization among non-caretaker adults did not result from HIP's nonemergency ED copay policy, but rather is an artifact of other factors that may have contributed to ED utilization decline, including contemporaneous efforts by health plans to increase patient education, target frequent ED users for better care coordination, and so forth.

In contrast to Indiana's dubious data, published peer-reviewed literature to date shows that nonemergency ED copays have not proven effective for reducing nonurgent use of the ED in low income public insurance programs.[52] Based on this data and the above analysis, we can only conclude that Indiana's proposal to charge graduated copayments for nonemergency use of the ED is not only beyond the Medicaid statutory limits, but it is highly unlikely to be an effective policy for reducing nonemergency ED utilization.

[52] David J. Becker et al., *Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program*, 70 Medical Care Research Review 514–529 (2013); Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments*, 29 Health Affairs 1643 (2010).